A. Business Purpose and Foundations

Index	Data Reference	Sources, Assumptions, Methodologies
A.1	• **Non-profit plans in Washington, D.C. are required to offer Open Enrollment**	◦ **Sources:** - West Group (dccode.westgroup.com), *District of Columbia Official Code §31-3514*, 2001 Edition
A.2	◦ **CareFirst Open Enrollment Membership in the District of Columbia**	◦ **Sources:** - CareFirst, enrollment data, December 2001 • **Methodologies:** - Open enrollment number given represents the number of members enrolled in open enrollment products in Washington, D.C. only
A.3	◦ **CareFirst's exit from Medicare+Choice and Medicaid Risk**	◦ **Sources:** - Accenture, interview with CareFirst executives, January 2002
A.4	• **Health Plans exiting Medicare and Medicaid**	◦ **Sources:** - Center for Health Care Strategies, Inc., *Transitioning Clients When Plans Exit Medicaid Managed Care Programs*, March 2001 - Managed Care On-Line (MCOL), *Medicare+Choice Plan Withdrawals*, July 25, 2000
A.5	• **In Maryland, the Health care Foundation is statutorily created**	◦ **Sources:** - Maryland General Assembly website (mlis.state.md.us), *Insurance code*, 2001 ◦ **Methodologies:** - §6.5-301 States: > (a) The appropriate regulating entity shall approve an acquisition unless it finds the acquisition is not in the public interest. (b) An acquisition is not in the public interest unless appropriate steps have been taken to: (1) ensure that the value of public or charitable assets is safeguarded; (2) ensure that: (i) the fair value of the public or charitable assets of a nonprofit health service plan or a health maintenance organization will be distributed to the Maryland Health Care Foundation that was established in §20-502 of the Health- General Article… - §20-502 States: > There is a nonprofit Maryland Health Care Foundation established to promote public awareness of the need to provide more timely and cost-effective care for Marylanders without health insurance and to receive moneys that can be used to provide financial support to programs that expand access to health care services for uninsured Marylanders.
A.6	◦ **Missions of Foundations Created from BCBS Conversions,** possible mission of D.C. and DE foundations	◦ **Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001 - Health Plan press releases - Community Catalyst website - The Foundation Center website - Individual foundation websites ◦ **Assumptions:** - Foundations created from the conversion of BCBS plans followed the *cy pres* doctrine, since all foundations resulting from converting Blues plans to date have health care as their sole mission. This is true even in states that lacked legislative requirements which dictated that foundation money must be spent on health care. - Grantmakers in Health describes the concept of the *cy pres* doctrine as follows: > "This trend [the transfer of assets from a non-profit foundation to another type of health organization] is supported by the *cy pres* doctrine, which supports an application of the assets to a mission as close as possible to that of the original nonprofit organization."
A.7	• **Per Capita Analysis of Foundations** Created by the	• **Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001

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	Conversion of BCBS Plans	- Health Plan press releases - Community Catalyst website - The Foundation Center website - Individual foundation websites - U.S. Census Bureau, *State and County QuickFacts*, 2000 ∘ **Methodologies:** - Per capita foundation amount = Foundation asset amount ÷ Appropriate population > Foundation asset amount = The most recent total asset amount given for foundations created as a result of a conversion of a BCBS health plan was used. > Appropriate population = The Census Bureau provided the 2000 population data for each state where a foundation was created. ≈ For MD, DC and DE, the populations have been combined.
A.8	∘ **Addition of PBO foundations could increase Annual Amount of Health Care Grants Awarded in Maryland, Delaware, and Washington, D.C. by 97%-107%**	∘ **Sources:** - The Foundation Center, a customized report extracted from the *Foundation Grants Index*, December 2001 ∘ **Assumptions:** - The current annual amount of health care grants awarded in Maryland, Washington, D.C. and Delaware in 2000 is extracted from The Foundation Grants Index by The Foundation Center. The Foundation Grants Index is based on grants of $10,000 or more awarded for health organizations and health related activities by a sample of 1,015 larger foundations. The Foundation Grants Index is not inclusive of every grant awarded for health organizations and health related activities in Maryland, Delaware, and Washington, D.C., but represents one of the most comprehensive databases assembled on this subject. - The grants awarded were for health organizations and health-related activities as classified under the National Taxonomy of Exempt Entities as codes E, F, G and H. ∘ **Methodologies:** - Percentage increase in health care grants in MD, DE, DC = CareFirst foundations potential annual grant amount ÷ Current annual grant amount > Current annual grant amount = Report showed current annual amounts awarded in Maryland ($31M), Washington, D.C ($11M) and Delaware ($18M) for a total of $61M given in the three areas. > CareFirst foundations potential annual grant amount = Range of grants that the CareFirst foundations could potentially award ($59M-$65M). See "Estimated Annual Dollar Amount Awarded by CareFirst Foundations" - The CareFirst potential annual grant amount ($59M-$65M) divided by the current annual grant amount ($61M) results in a 97%-107% increase in annual health care grants in Maryland, Delaware, and Washington, D.C. - The sum of CareFirst foundations potential annual grant amount and the current annual grant amount should equal to between $120M-$126M.
A.9	∘ **Estimated Annual Dollar Amount Awarded by CareFirst Foundations and the HealthCare Georgia Foundation**	∘ **Sources:** - The Foundation Center, the Foundation Directory Online, 2001 - WellPoint and CareFirst, *Agreement and Plan of Merger*, November 2001 - IRS, *Handbook 7.8.3 Private Foundations Handbook*, 2001 ∘ Assumptions: - The percentage of total assets spent on grants in 2000 by the largest foundations in Georgia, Maryland, Washington, D.C. and Delaware who have health care as a part of their mission can be applied to the CareFirst foundations and HealthCare GA to estimate a range of the annual amount of grants the new foundations could award. ∘ **Methodologies:** - Percentage of total assets spent on grants by the largest foundations that

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		include "health care" as a part of their mission = Straight and Weighted Averages of (Amount of grants given in 2000 by each foundation + Amount of assets for each foundation in 2000) > Amount of grants given in 2000 by each foundation (in Maryland, Delaware, and Washington, D.C.) = Identified the five largest foundations within the Maryland, Delaware, and Washington, D.C. area that include "health care" as a part of their mission. These five foundations are listed below in order of total assets (year 2000, largest to smallest); the sum of grant monies each foundation awarded in 2000 is provided in parentheses. ≈ Morris and Gwendolyn Cafritz Foundation, DC ($13.2M) ≈ The J. Willard and Alice S. Marriott Foundation, DC ($11.1M) ≈ The Abell Foundation, MD ($12.7M) ≈ France-Merrick, MD ($11.3M) ≈ The Crystal Trust, DE ($7.1M) > Amount of grants given in 2000 by each foundation (in Georgia) = Identified the five largest foundations within Georgia that include "health care" as a part of their mission. These five foundations are listed below in order of total assets (year 2000, largest to smallest); the sum of grant monies each foundation awarded in 2000 is provided in parentheses. ≈ Robert W. Woodruff Foundation ($149.9M) ≈ Community Foundation for Greater Atlanta ($22.1M) ≈ Bradley-Turner Foundation ($20.7M) ≈ Callaway Foundation ($7.8M) ≈ Carlos and Marguerite Mason Fund ($5.5M) > Amount of assets for each foundation in 2000 = Data from The Foundation Center - The average amount of assets awarded by these foundations was 4.9%. The weighted average was 4.8%. - The IRS *Private Foundations Handbook*, Chapter 6 states that: "a private foundation must make qualifying distributions ... equal to substantially all of the lesser of its: 1) adjusted net income, or 2) minimum investment return (5% of the fair market value of the foundation's assets)". This effectively means that private foundations must pay out approximately 5.0% of their assets each year (some of this 5.0% may go to administration) in order to maintain their non-profit status. - Based on the calculations above and the IRS *Private Foundations Handbook*, it is reasonable to apply 4.8-5.0% range to the $1.3B Total Assets of the CareFirst foundations and the $113M Total Assets of HealthCare Georgia. To be conservative, however, the range that was applied was 4.5-5.0%. By multiplying 4.5-5.0% by $1.3B, an estimated range of annual giving is $58.5M-$65.0M that the CareFirst foundations could donate annually to health care. The range of 4.5-5.0% was also applied to HealthCare Georgia, to arrive at an estimated range of $5.1M-$5.6M that the HealthCare GA Foundation could donate annually to health care.
A.10	**Foundations Created by Health Plan or Hospital Conversions in CareFirst's Jurisdiction and Georgia and Their Annual Grants Awarded (2000)**	**Sources:** - Grant Makers in Health, *A Profile of New Health Foundations*, March 2001 - The Foundation Center, *The Foundation Directory Online*, 2001 **Assumptions:** - The data is presented by comparing the current amount of actual grants awarded by foundations created by health care conversions in each jurisdiction in 2000 and the potential grant amount if the CareFirst and HealthCare Georgia foundations were operational. Since 2001 grant data is not yet available it is not possible to compare the current amount of annual grants to the current value of the CareFirst foundations or HealthCare GA. - In one instance (Georgia Osteopathic Institute), 2000 grant data was not

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		available. In this case, we assumed they grant at the same rate as other foundations, so we applied the percentage of assets that the other foundations gave in grants to the GA Osteopathic Institute to complete the calculations. • **Methodologies:** - The foundations created by health care conversions in Maryland and Washington, D. C. are listed below with the annual amount of grants given in 2000 (to date, no foundations have been created from health care conversions in Delaware): > Consumer Health Foundation, DC ($1,100,573) > The Horizon Foundation, MD ($2,611,438) ≈ The Horizon Foundation was established in 1998 as a result of the merger of Johns Hopkins Medicine with Howard County General Hospital. Although both merging entities were non-profit organizations, and therefore, were not required by Maryland regulations to establish a foundation, the Board of Directors nonetheless decided to create The Horizon Foundation. - By adding the range of grants that the CareFirst foundations could potentially award ($59M-$65M), the new annual amount given to health care in Maryland, Delaware, and Washington, D.C. by foundations created from a conversion increases from $4M to between $63M-$69M. - The foundations created by health care conversions in Georgia are listed below with the annual amount of grants given in 2000: > Georgia Osteopathic Institute, ($136,849, estimated) > Health 1st Foundation, ($240,000) > Spaulding Health Care Trust, ($438,237) > Georgia Health Foundation, ($478,237) - By adding the range of grants that the HealthCare Georgia Foundation could potentially award ($113M x 4.5%= $5.1M and $113M x 5.0%=$5.7M), the new annual amount given to health care in GA by foundations created from a conversion increases from $1.3M to between $6.4M-$7.0M.
A.11	• **California Endowment grants in 2000**	• **Source:** - The California Endowment, *The Changing Faces of Health*, 1999-2000 (annual report) • **Methodologies:** - Percentage of assets awarded in grants = Annual amount awarded in grants ÷ California Endowment's total assets > Annual amount awarded in grants = The CA Endowment's fiscal year ended in February 2000. The foundation awarded $197M in grants during the year. > California Endowment's total assets = at the end of February 2000, the endowment's assets were valued at $3.7Billion.
A.12	• **CareFirst Funding Used to Expand the Medicaid Program**	• **Sources:** - KPMG Report to the Maryland Health Care Foundation, *Meeting Unmet Health Care Needs in Maryland: Priority Issues and Investments*, November 2001 - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 2000*, September 2001 - U.S. Census Bureau, *State and County QuickFacts*, 2000 • **Assumptions:** - In the report, KPMG uses an average health care insurance cost of $2,500 per capita, with 50% of this amount being subsidized by the federal government since individuals qualify for federal matching funds. Therefore, the average cost of insuring an individual who qualifies for federal matching funds is $1,250. - The $1,250 has been applied to cover individuals in Maryland, Washington, D.C. and Delaware for this analysis. - We have assumed that there are at least 52,000 individuals in the three

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		jurisdictions that would qualify for federally subsidized Medicaid. • **Methodologies:** - Number of uninsured that CareFirst foundations can cover = Estimated annual amount awarded by CareFirst foundations ÷ Cost of covering one uninsured person > Estimated annual amount awarded by CareFirst foundations = $58.5M-$65.0M (see "Estimated Annual Dollar Amount Awarded by CareFirst Foundations") > Cost of covering one uninsured person = $1,250 (see assumption above regarding KPMG's use of $2,500 as the per capita average health care insurance cost) - This calculation estimates that CareFirst foundations could insure a range of 46,800 to 52,000 people through expanding the Medicaid program.
A.13	• **Comparison of Charitable Giving By Blue Cross Blue Shield of Georgia and Blue Cross of California Pre vs. Post Conversion**	• **Sources:** - WellPoint, November 2001 - Blue Cross Blue Shield of Georgia, November 2001 • **Methodologies:** - Percentage change in charitable giving = Charitable giving post-conversion ÷ Charitable giving pre-conversion - Charitable giving post-conversion > For both companies, post-conversion years were 1996-2000 ≈ Blue Cross Blue Shield of Georgia donated on average $798,000 per year ≈ WellPoint donated on average $777,000 per year - Charitable giving pre-conversion > For both companies, pre-conversion years were 1993-1995 ≈ Blue Cross Blue Shield of Georgia donated on average $413,000 per year ≈ WellPoint donated on average $555,000 per year - BCBS GA has shown a 93% increase in post-conversion donations and WellPoint has shown a 40% increase.
A.14	• **Percentage of Uninsured in California, Georgia and other States Where Blues Plans Have Converted**	• **Sources:** - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 2000*, September 2001 - U.S. Census Bureau, *Current Population Reports- Health Insurance Coverage: 1997*, September 1998 • **Assumptions:** - Blues plans in thirteen states converted to for-profit status prior to 2000 and are now operating as Anthem, Cobalt, Trigon and WellPoint. Although Anthem has announced its intent to acquire Blue Cross Blue Shield of Kansas, this sale was excluded from our analysis because Blue Cross Blue Shield of Kansas has not yet completed its conversion. - The U.S. Census Bureau added a "verification" question to its 2000 survey which produced a lower and more accurate estimate of the uninsured. Only 1998 and 1999 survey data results have been modified to reflect this change. Therefore, a trend cannot be drawn between uninsured rates reported prior to 1998. • **Methodologies:** - Definition: Compound annual growth rate (CAGR) = (Number at the end of the period ÷ Number at the beginning of the period)$^{(1 \div \text{number of years in the period})}$ - 1 - Compound annual growth rate (CAGR) of the percentage of uninsured in California, Georgia and other States where Blues plans have converted = (2000 Uninsured Rate ÷ 1998 Uninsured Rate)$^{0.5}$ - 1 > Georgia Example:

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		≈ 2000 Uninsured Rate – 0.144
		≈ 1998 Uninsured Rate – 0.163
		≈ Divide the 2000 Uninsured Rate (.144) by the 1998 Uninsured Rate (.163) to arrive at .883. Take .883 to the power of (1/(2000-1998)) or ½. and subtract 1. Multiply this number by 100 (to turn the number into a percentage) to arrive at -6.0%. This is the rate the uninsured population has decreased in Georgia between 1998 and 2000.

B. Competition

Index	Data Reference	Sources, Assumptions, Methodologies
B.1	• **Companies licensed to transact health insurance in Maryland, Delaware, and Washington, D.C.**	• **Sources:** - InterStudy, *HMO Directory*, 11.2 edition (2000 data) - InterStudy, *PPO Directory and Performance Report*, 2.0 edition (2000 data) • **Methodologies:** - Unique is defined as insurers that have different parent companies/ownership - The number of unique HMO and PPO insurers listed in the InterStudy directories were counted within CareFirst's jurisdictions: Maryland, Delaware and Washington D.C. > Combined, there are 54 unique HMO and PPO insurers ≈ 6 insurers offer both PPO and HMO plans > There are 16 unique HMOs operating in the three CareFirst jurisdictions ≈ 4 HMOs serve members in all three CareFirst jurisdictions ≡ Aetna U.S. Healthcare ≡ CareFirst, Inc. ≡ CIGNA HealthCare ≡ Mid-Atlantic Medical Services, Inc. > There are 44 unique PPOs ≈ Approximately 60% operate in all CareFirst three jurisdictions
B.2	• **Definition of "Medical Coverage"**	• **Sources:** - CareFirst, product marketing materials, 2001 ◦ **Methodologies:** - CareFirst defines medical coverage as members who are enrolled in individual, small group, or large group medical service products including HMO, PPO, POS, and Indemnity plans. Members enrolled in Ancillary products such as dental and vision plans only are not considered "medically covered members."
B.3	• **CareFirst market share:** CareFirst membership divided by the eligible population residing in each CareFirst jurisdiction	◦ **Sources:** - WellPoint, enrollment data, September 2001 - CareFirst, enrollment and population data, June 2001 utilizing: > CACI Marketing Systems' Scan/U.S. demographic software based on Census 1990 data > Employee Benefits Research Institute, *Primary Sources of Coverage*, 1999 data • **Assumptions:** > As noted below, WellPoint provided Unicare membership by state of residence. In order to match Unicare members with CareFirst jurisdictions, we had to exclude the Unicare members residing in Montgomery and Prince George counties. We assumed that total Unicare Maryland membership multiplied by the percentage eligible population in Montgomery and Prince George (as a portion of Maryland's total eligible population) would serve as a reasonable proxy for Unicare membership in these two counties. ◦ **Methodologies:** - CareFirst membership was divided by the "eligible population" residing in each CareFirst jurisdiction. > Eligible population is defined as the population that is covered by commercial insurance and excludes the uninsured, CHAMPUS, and 65+ with traditional Medicare only ≈ Scan/U.S. software projected June 2001 population counts for each county for residents aged <65 and 65+ ≈ The *Primary Sources of Coverage* report estimated the percentage of population aged <65 and 65+ that were not covered by commercial insurance in 1999 > CareFirst Maryland is comprised of all counties except Montgomery and Prince George - these two counties border Washington, D.C. and are considered part of CareFirst's Washington, D.C. affiliate, formerly Blue Cross Blue Shield of the National Capital Area.